Strategies for Change

Comprehensive Reform of Ontario's Long-Term Care Services

Ontario

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Preface

This paper is intended for all individuals interested in long-term care reform including service providers, consumers, and advocates.

It is available in French and English through the Ontario Government Bookstore, 880 Bay Street, or by writing to:

Publications Ontario
5th Floor
880 Bay Street
Toronto, Ontario
M7A 1N8

or by telephoning:
in Toronto: 326-5300
in other Ontario communities: 1-800-668-9938

A pamphlet briefly describing the reform of long-term care, suited to a general audience, will be available in a variety of offices of the Ministry of Community and Social Services, the Ministry of Health, the Office for Disabled Persons and the Office for Senior Citizens' Affairs.

Ce rapport est aussi disponible en français

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Part I:
Introduction to Reform

Part I: Introduction to Reform

The primary goal of long-term care reform is to promote the well-being of Ontario residents through a coherent, well-managed system of community care and support.

A comprehensive reform of Ontario's long-term care and support services is now under way. In June 1989, the Government of Ontario announced its intention, as part of this reform, to develop a coordinated system of services that will meet the needs of individuals with functional dependencies related to physical disability and/or aging.

The main purpose of the reform is to build a coherent, integrated service system on the foundation of existing in-home, community support, and long-term care facility services. This means coordinating:

- access to service and information;
- an integrated program of care and support services in the home;
- planning for long-term care facility services (nursing homes, homes for the aged and chronic care);
- an enhanced system of community support services.

Community-based services will be emphasized to enhance self-reliance and to assist people to live in their own homes and communities.

Fundamental to the reform is the fact that Ontario already has many of the components of an effective long-term care and support service system. The reform builds on the current strengths and skills of successful health and social services. The strategies for developing a more coherent system, based on the existing services, are described in this paper.

The success of reform depends on the participation of consumers, their families and friends, advocates, volunteers, and service providers.

Purpose of the Paper

The purpose of this paper is twofold. *First, it outlines the strategic directions* for reforming long-term care and support services in the province. These strategic directions describe the essential service and management components of a reformed long-term care system, and are the starting points for reform as determined by the Ontario government.

Second, this paper provides a framework for community discussion. It identifies aspects of reform that will require further discussion, consultation, and community planning. The success of reform depends on the participation of consumers, their families and friends, advocates, volunteers, and service providers in the community consultation and planning activities that will follow the distribution of this paper.

Everyone is invited to participate in determining how these service directions and strategies might be applied in Ontario's communities. The reform of Ontario's long-term care and support services will involve years of cooperative work. Substantial challenges are to be expected at the local, regional, and provincial levels; however, partnerships among those involved will help to create a better service system for all.

The first step in reform is to identify strategies that will provide the essential components of an effective community care and support services system. These service strategies are discussed in Part II of this paper. The second step is to create management systems that will encourage the provision of high-quality, well-coordinated, and fiscally responsive services and maximize accountability in the service system. The mechanisms required to manage the reformed system are addressed in Part III.

Long-Term Care – The Current Situation

"Long-term care" refers to a range of community, personal support, and health care services required on a periodic or ongoing basis by individuals, who,

because of physical disability or aging, need assistance to function as independently as possible. A wide variety of service providers are involved in long-term care services: for-profit and not-for-profit agencies, voluntary organizations, hospitals, small programs that provide meals or friendly visiting, and large institutions that provide personal care and treatment.

Long-term care is a complex assortment of formal and informal services. The formal system, or publicly funded services, includes both health care and social services and involves professional and paraprofessional workers from many backgrounds. The informal network which involves the support and care given by family, friends, and volunteers, represents over 80% of help received. Women are the main participants in this system, not only as consumers, family members, and volunteers who provide informal care and support, but also as staff in formal services.

Why Reform Now?

Ontario has many excellent long-term care and support services. They represent a wide array of programs, but they are not integrated as a service system. The provincial government's investment in these services is significant. The total provincial cost is approximately $2 billion. This is in addition to the resources committed by individuals, families, volunteers, and charitable and municipal organizations.

The current collection of formal services has evolved over many years, and, while frequently dealing with similar consumer needs, operate under differing policies, funding arrangements, and legislation. Their main characteristics are listed in Appendix I.

At present, there is no structured and integrated mechanism to plan and manage these services as a whole. Finding and getting service is often confusing, inconsistent, and time-consuming for individuals and families seeking assistance.

Note on Terminology

During the review and planning period, phrases such as "long-term care" have been used to describe the system's programs and services. Attempts have been made to use more appropriate terms; however, in many cases, traditional terminology that is at least generally understood has been used. It is hoped that as discussions and reform planning proceed, new phrases will emerge that are meaningful, convey positive concepts, and reflect the new directions for services.

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Society's expectations with regard to personal lifestyle and independence have changed.

Because of New Expectations

Society's expectations with regard to personal lifestyle and independence have changed over the past several decades. Service recipients and their families are seeking more non-institutional services and greater participation in planning and managing their personal services. With appropriate support services, many elderly persons are able to remain in their own homes and lead relatively independent lives. Support services also sustain the substantial caregiving efforts of family members, friends, and neighbours.

People with physical disabilities are demanding greater autonomy in managing the services that enable them to be as self-reliant as possible. The success of the independent living movement has challenged conventional notions of health care and rehabilitation, and improved public awareness of the capabilities of people with disabilities. Improvements and enhancements must be made in the current support services system to facilitate independent living and greater community participation for all people with physical disabilities as well as elderly persons.

Because of Social Change

Ontario faces a number of pressures and trends that make reform a necessity.

For example, the "baby boom" population is aging; the size of the over-65 population is expected to double in the next thirty years. There is even more rapid growth in the number of individuals over age 85, who may require greater amounts of health and social services.

Life expectancy has increased for everyone, including persons with severe disabilities. As a result, the proportion of Ontario's population that depends on some form of assistance with the activities of everyday living is increasing.

In the future, as the population ages and the birth rate continues to be low, Ontario's over-85 population may experience a reduction in the number of caregivers. Increasing numbers of women working outside the home, rising divorce rates, and smaller families will also contribute to the reduced number of informal caregivers. In addition, the number of single-person households is increasing, with the result that more people live isolated lives.

Improved medical interventions and new technologies are saving lives. As a result, there are more groups with unique service requirements, such as individuals who have traumatic head injuries or who depend on special technical supports such as ventilators.

Another trend to consider is that Ontario's population, including consumers and service providers, is becoming increasingly multicultural. Services must respond to the needs and concerns of the province's diverse cultural communities.

Services in Aboriginal communities should reflect the traditions and changing responsibilities of those communities.

Services must be responsive to the service needs of Franco-Ontarians and reflect the province's linguistic duality.

Ontario's long-term care and support services must be ready to meet the challenges posed by these social trends.

Ontario's long-term care and support services must be ready to meet the challenges.

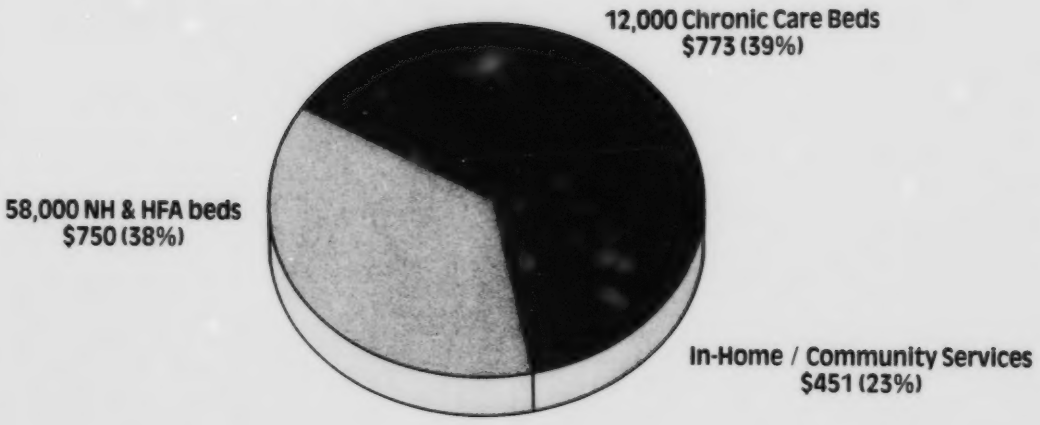
Because of Growth in Service Demand and Cost

At present, then, Ontario is faced with serious pressures related to services.

- The demand for services is increasing, as is the cost of services.
- Access to services is sometimes confusing and inconsistent.
- Avoidable and premature institutionalization occurs.

The demand for services is increasing, as is the cost of services.

Long-Term Care System –
Division of Resources
($Millions)



TOTAL: $2 billion
based on 1987 / 88 Estimate

- Inadequate access to in-home and community support services results in the over-use and inappropriate use of higher-cost services; for example, more than 10% of Ontario's 17000 acute care hospitals beds are used by people who, in fact, require long-term care and support services.

In summary, new consumer expectations, emerging needs, social trends, and resource pressures have made a comprehensive reform of Ontario's long-term care and support services system necessary to prepare for our future.

Recommendations to the Ontario Government

The goal of reform is consistent with recommendations made in recent major reports presented to the government of Ontario, and resulting in the establishment of the Premier's Council on Health Strategy. For example, the Evans report, *Toward a Shared Direction for Health in Ontario*, highlights: 1) strengthening the role of the individual, 2) coordinating and integrating services, and 3) focusing on community alternatives. *Independence and Control: Today's Dream, Tomorrow's Reality, and Independent Living: The Time is Now*, identify ways of improving support services to maximize independence for individuals with physical disabilities. Strategies for reform reinforce the province's commitment to independent living as identified in the *Proclamation of the Decade of Disabled Persons*(1983-1992). *A New Agenda* establishes a provincial commitment to improve health care and community support services for elderly persons. The activities of long-term care reform expand on this commitment.

The Reform Process

In partnership with his colleagues from Health, Senior Citizens' Affairs and the Office for Disabled Persons, the Minister of Community and Social

Discussions regarding long-term care reform have been held with many provincial organizations, consumers, advocacy groups, service providers, and volunteers in Ontario communities.

Communities will be invited to establish a local planning process to review the strategic directions, resolve local problems, build partnerships, and prepare a local implementation plan.

Services was given lead responsibility in 1989 to address the reform of long-term care. A steering committee of assistant deputy ministers and senior directors from the Ministry of Health, the Office for Senior Citizens Affairs, the Office for Disabled Persons, the Ministry of Community and Social Services, the Cabinet Office and the Management Board of Cabinet, was formed. It is chaired by an assistant deputy minister whose responsibilities include both health and social service mandates.

A provincial government task force, reporting to the steering committee, has reviewed the province's long-term care and related support programs, as well as the results of numerous reports, program reviews, and journal articles. It has considered the experiences of other provinces and countries that have met the kinds of challenges Ontario faces. Discussions regarding long-term care reform have been held with many provincial organizations, consumers, advocacy groups, service providers, and volunteers in Ontario communities.

Initial discussions in communities across the province during the summer of 1989 have indicated strong support for the directions of the reform. There were requests for more detail and for an opportunity for wider community discussion. This paper is a response to these requests and signals the next step in the consultation process.

Throughout the summer and fall of 1990, community information and consultation meetings will be held to discuss the reform strategies outlined in the following sections.

Many Ontario communities are now conducting comprehensive health system reviews which focus on a wide range of community-based and institutional services. The scope of health services planning is becoming broader and involving wider community participation. This paper will help provide direction for these reviews and enhancement of the community long-term care services system.

The responsibility for the long-term care and support programs of the Ministry of Health and the Ministry of Community and Social Services, has been

vested in an integrated provincial management structure, the Division of Community Health and Support Services. This new division includes staff from both ministries. Their first task will be to work cooperatively with local communities and organizations in planning for the reform.

The Scope of the Reform

Planning the reform has embraced key components of a long-term care and support service system. The reform initiative has examined many programs and services: homes for the aged, nursing homes, chronic care services, Home Care, the Integrated Homemaker Program, Outreach Attendant Care, Homemakers and Nurses Services, Home Support Services, Elderly Persons (or Older Adults) Centres, Alzheimer Community Programs, day programs, day hospitals, Regional Geriatric Programs, and volunteer programs.

It has been necessary, however, to set some limits to reform. Several very important and related areas have not been included within the parameters of the reform. These include assistive devices and rest and retirement homes.

Other models and services, such as Comprehensive Health Organizations, Hospital-in-the-Home, palliative care, psychogeriatric services, supportive housing for the elderly, and Support Service Living Units for physically disabled individuals, are being discussed in tandem with the reform initiative.

Considerations for Reform

The reformed system of long-term care and support services must take into special consideration the heterogeneity of cultures in Ontario. Particular efforts are required to ensure that services are responsive to the concerns and interests of the province's diverse communities. These considerations are discussed below.

Aboriginal peoples comprise approximately 2% of Ontario's population. The federal government, with

The responsibility for the long-term care and support programs of the Ministry of Health and the Ministry of Community and Social Services, has been vested in an integrated provincial management structure, the Division of Community Health and Support Services.

Consultation on long-term care reform will seek to engage Aboriginal communities in specific, separate forums to discuss their ideas, issues, and concerns regarding long-term care and support service provision.

The Ontario government is encouraging service agencies and organizations to be responsive to the information and service needs of francophones in their communities.

the consent of the Aboriginal peoples, retains basic responsibility for the provision of services to Aboriginal peoples. The Ontario government, however, also provides and will continue to provide services, both on and off reserves, to Aboriginal peoples as residents of Ontario.

It is important that the new framework for the design, delivery, and administration of long-term care and support services is supportive of, and can accommodate the First Nations' move toward self-government and self-determination.

The design and delivery of services should recognize the uniqueness of Aboriginal communities and support the protection of Aboriginal culture.

Consultation on long-term care reform will seek to engage Aboriginal communities in specific, separate forums to discuss their ideas, issues, and concerns regarding long-term care and support service provision.

Approximately 500000 **francophones** live in Ontario. The *French Language Services Act*, 1986, acknowledges the historical linguistic duality of Ontario and the long-standing contribution of Franco-Ontarians to the province. Under the regulations to this Act, the Ontario government is committed to providing its services and program information in both English and French in twenty-two designated areas of the province.

The reform of long-term care must be responsive to the information needs of francophones in their communities and the appropriate provision of services. The designation of specific agencies to provide services in French has already begun. Providers wanting to establish such services will be supported by the government's *French Language Services Act*.

To ensure the involvement of Franco-Ontarians in the public consultation process, translation services will be available upon request for consultations in the designated areas of the province. In addition, a French version of this report is being distributed.

Ontario is a culturally diverse society with numerous **ethno-cultural communities**. Approximately 25% of Ontarians were born outside of Canada.

Ontario's multiculturalism policy welcomes and acknowledges this diversity and is dedicated to ensuring that people of all cultures and races have equal opportunity in all aspects of society. Government policies, appointments, and programs must reflect the spirit of this policy.

The philosophy and objectives of the current comprehensive reform of services is supportive of Ontario's multicultural policy and conducive to addressing the needs of ethno-cultural groups.

Enhancing the role of local communities in planning, establishing priorities, and managing services emphasizes the principle of local design as instrumental in meeting the needs of ethno-cultural populations. These key objectives of the reform process require representation and suggestions from ethno-cultural groups.

In summary, services must recognize the individual needs of elderly persons and persons with disabilities in all communities, including Aboriginal, francophone, and diverse ethnic communities. The public discussions, which will take place in the summer and fall of 1990, will seek to provide these communities with opportunities to express their ideas and concerns about the reform process.

Service providers are encouraged to offer programs and services that can be utilized by multicultural communities.

Principles of Reform

A set of principles were developed in 1989 to reflect the values upon which the reform of long-term care and support services would be based. These principles have been revised following initial discussions with community groups, and they are listed below.

1. Individualization

Services must be responsive to widely varying individual requirements in order to help people in an appropriate and flexible manner. Inherent in this principle is the belief that the dignity and uniqueness of each individual must be recognized and respected.

2. **Independence and Choice**

   Independence involves the individual's freedom to make lifestyle decisions in the course of daily living and reflects the right to make choices and take risks. Services should be designed, and operate, in ways that maximize the independence and choice of consumers.

3. **Community Living**

   The service system should strive to provide services and options that will assist people to live in their own homes and communities whenever possible.

4. **Service Accessibility**

   The service system should provide a clearly identifiable point of access to services. Access should be simplified and integrated in order to be responsive to individual needs.

5. **Support for Informal Caregivers**

   This principle recognizes the important role that family members, friends, neighbours, and volunteers often perform in providing assistance to many individuals. Services that complement and sustain informal caregiving must be recognized as an integral part of the service system.

6. **Local Planning and Management**

   The service system will be planned and managed locally to develop the most suitable services for community needs. This service planning and management will occur within the framework of provincial standards and policy directions.

7. **Affordability**

   The service system must be affordable within the limits of provincial fiscal policy, and available resources must be used effectively to meet needs. The costs of services should be shared fairly among levels of government and consumers.

Part II:
Strategies for Service Change

Part II: Strategies for Service Change

In order to focus our collective energies on reform, it is important to share a vision of a fully developed, integrated, coordinated service system. The following sections discuss the strategies to develop a coherent system built upon the base of existing programs and services.

Six main service components have been identified as essential to the service system and are described below.

Service Access Organizations provide a readily identifiable, simplified way for people to access services.

1. **Service Access Organizations** provide a readily identifiable, simplified way for people to access services. An authorized agency in each of thirty-eight or more areas of the province will ensure that people receive information, referral, assessment, and service coordination if needed, and appropriate personal support and care services. This organization will build on the successes of the Home Care Program and Placement Coordination Services.

The objective of in-home services is to enable people to live in their own homes and communities and to function as independently as possible.

2. **In-Home Services** are a critical core of formal personal support and professional care services provided in a person's home. The objective of in-home services is to enable people to live in their own homes and communities and to function as independently as possible. In-home services should be provided in a flexible and responsive manner based on each individual's needs and situation. People may require service for various lengths of time, perhaps briefly after discharge from hospital, intermittently, or for extended periods. As is currently the case, school-age children may receive these services in publicly-funded school

Community support services, promote individual self-reliance and well-being.

settings. In-home services incorporate the existing Home Care (Acute, Chronic, and School), Integrated Homemaker, Outreach Attendant Care and Homemakers and Nurses Services programs, and the Home Support homemaking services.

3. **Community Support Services** represent a range of supportive services, including meal services, home maintenance services and escorted transportation. They play a critical role as complements to in-home and other formal services and to the assistance provided by family and friends. Through Community support services, volunteers and self-help groups, community organizations such as multicultural centres, and religious organizations promote individual self-reliance and well-being. Also, they are often the first level of service requested by individuals and families, and they play an important role in preventing and delaying the need for more formal services.

Specialized Services deal with the complex or unique needs of consumers who require specific expertise.

4. **Specialized Services** deal with the complex or unique needs of a relatively small number of consumers who require specific expertise. These services include specialized professional assessment, treatment, consultation and education. Because of their relative scarcity, specialized services are not available in all geographic areas. This component of the service system includes the Regional Geriatric Programs, day hospital programs, and specialized day programs.

Support services for informal caregivers are an integral part of a long-term care and support service system.

5. **Informal Support and Care** is the assistance provided by families, friends, volunteers and other "informal" caregivers to individuals who require assistance with everyday activities. Informal caregivers may require diverse means of support, including information about chronic conditions, self-help groups, and respite services. Support services for informal caregivers are an integral part of a long-term care and support service system.

6. **Long-term Care Facilities** provide treatment, care, and support for people whose needs cannot be met appropriately, safely or effectively in their own homes. This service component includes nursing homes, homes for the aged, and chronic care services.

The following sections outline the strategies required to develop a coherent system based on these service components.

Long-term Care Facilities provide treatment, care, and support for people whose needs cannot be met appropriately, safely or effectively in their own homes.

Coordinate Access to Services

Service access organizations will be identified or established across the province to provide consumers with a local, integrated point of access to in-home services, and long-term care facilities. Service access organizations will provide assessment, service coordination, and referrals to community support services, if required.

In order to develop a truly integrated system of long-term care and support services, a new co-ordinating mechanism is required. A single administrative organization, or agency, will be identified or established in each community to act as the point of access, referral, assessment, and service coordination for the care and support services of the reformed system. The service access organization will also provide referrals to other services and resources in the community.

Purpose of the Service Access Organization

The service access organization will ensure that people who require support and care services receive them in their own homes and communities wherever possible. It will provide entrance to a full range of services and will assist consumers in considering the choices and options available to them.

When community options are not appropriate to meet an individual's needs, the service access organization will provide the point of access to long-term care facility services (nursing homes, homes for the aged, chronic care). In general, the service access organization will create a focal point for resources and services and will make possible the targeting of resources to those most in need and most able to benefit from them.

The service access model builds on the "one stop access" concept first introduced in *A New Agenda* as an integrated "one-stop shopping" approach to obtaining services. The model will serve people of

all ages with functional dependencies related to aging and/or physical disability. A review of systems in other jurisdictions, an analysis of current pressures and trends in Ontario, and discussions with service providers and consumers have resulted in government's conviction that a unified access approach will greatly improve and simplify consumers' access to services, allow for full and effective use of community resources and alternatives, and provide a focus for the coordination of the service system.

Scope of the Service Access Organization

Some services, particularly community support services and volunteer services, respond to a broad range of individual needs and do not usually require assessment or service coordination. These services will continue to be directly accessible by consumers. The community service access organization, however, will have current information about these services and can refer consumers to them.

Other services, primarily long-term care facilities and in-home services, require a determination of individual needs and of the most appropriate ways of meeting those needs.

Further deliberation is required to clarify the relationship between the service access organization and specialized services such as Regional Geriatric Programs, whose expertise will be required by both the acute care system and the long-term care and support system. This relationship must be defined through community consultations and implementation planning.

What the Service Access Organizations Will Provide

The functions of the service access organization will be:

- to receive referrals by consumers, informal caregivers, professionals, and other service providers;

Access to long-term care facilities, in-home services, and some specialized services will be through the service access organization.

- to provide service information, and referral to other services as appropriate;
- to arrange or provide functional and social assessment where appropriate;
- to develop and coordinate individual service plans with individuals and their family members or friends;
- to manage resources for assessment and coordination of services, and to purchase in-home services as indicated by service plans;
- to provide access to long-term care facility services; and
- to coordinate waiting lists and set priorities for needs.

As part of the government's review of the advocacy needs of Ontario's citizens, the development of an advocacy function in the service access organization will be considered. A means for consumer appeals also needs to be considered.

The service access organization will have major responsibilities for assessment and service coordination, where required. The service coordinator's role will be to ensure that consumers' needs are addressed in a flexible way that respects their autonomy and choice.

Elements of this approach now exist in the integrated management and case management services of Home Care and the Integrated Homemaker Program and in the Placement Coordination Services in many communities. The experience and skills present in these services are an excellent foundation upon which to build the access organization for the reformed system. Further discussion is required to identify the important relationship between the service access organizations and acute care hospitals, hospital discharge planners, physicians, specialized programs, and public health services, as well as cooperation with long-term care facilities.

One of the major functions of a successful service access organization is effective **service coordina-**

tion. For the purpose of long-term care reform, service coordination is defined as *a process that assists people in problem-solving activities such as identifying needs, exploring solutions, and mobilizing both formal and informal support services to achieve and maintain the highest possible level of independence.* Also known as case management, it is provided in a variety of settings by Ontario's health and social services. Within the context of Ontario's long-term care reform, service coordination will draw on a blend of approaches now used in the health and social service sectors.

From the consumer perspective, service coordination may provide information and referral, assessment services, service plans, contact with appropriate service providers, and ongoing monitoring and support. It also provides linkages, information exchange, and coordination among programs and services, and promotes the effective and efficient use of resources.

Service coordination should be flexible in order to provide as little intervention as is required by the individual and to encourage consumers' participation in service planning.

A special responsibility of the service access organization is the **access to long-term care facilities.** The service access organization will provide a facility placement committee, which will review all applications for placement in long-term care facilities. *The committee will be responsible for ensuring that all community and in-home service options have been fully explored and exhausted before placement is approved.*

The committee's membership should be multidisciplinary, and the experienced participants should include a geriatrician or other physician, a community nurse, a social worker, an occupational therapist or physiotherapist, and a consumer representative. *The facility placement committee will assume sole responsibility for authorization of extended care certificates and will determine eligibility for admission.*

Service coordination will draw on a blend of approaches now used in the health and social service sectors.

Facility placement committees must address whether individuals can be cared for appropriately in their own homes.

The facility placement committee should not remove freedom of choice from the consumer or service provider, but direct that choice on the basis of priority of need and availability of resources.

The central question that facility placement committees must address is whether individuals can be cared for appropriately in their own homes, within acceptable margins of safety and within resource limits. When reviewing an application for long-term care placement, the committee will consider assessment information, the individual's requirements and wishes, whether other options have been explored, service availability, and their knowledge of individual facilities in determining the appropriateness of a long-term care facility placement.

A suitable sponsoring organization for service access will be identified in thirty-eight or more catchment areas.

Sponsorship of the Service Access Organization

Sponsoring agencies for service access may be existing or new organizations, *other than current direct providers of service*. Appropriate local sponsoring organizations will be recommended within the context of a community planning process.

Criteria for identifying or selecting the service access organization will be developed. They must include the organization's ability to work effectively with many service providers, its capacity for financial management, and its credibility in the community. The criteria will be developed by ministry staff and an advisory group established to assist in the reform.

Budgetary Responsibility

The service access organization will require a budget for administration and service coordination and for operating a facility placement committee. Also, it will have a budget for purchasing formal in-home services. This is similar to the way Home Care operates now. Changes in the way resources are allocated for community services and are used to purchase services are discussed under Strategy #4.

The service access organization will not control the budgets for community support services, such as meals-on-wheels and home maintenance services, or for long-term care facility services. Community support and facility services will be funded directly by the province. Community support services, however, may be purchased by a service access organization on behalf of some consumers.

Considerations for Reform

The development of a service access organization at the community level must be responsive to individual needs and to the preference of many consumers not to receive unnecessary assessment and service coordination. Many consumers will want to continue to manage their personal support services. In keeping with this approach, assessment and service coordination must be tailored to suit individual needs. In addition, an individualized funding model for consumers who prefer an alternate approach to meeting their service requirements is being considered.

Special solutions are required to meet the challenges posed by geographically large areas such as northern Ontario and densely populated areas such as Metropolitan Toronto. Catchment areas in northern Ontario may need to be redefined to allow for local or community representation and an equitable distribution of resources. In Metropolitan Toronto, several linked service access organizations may be required to ensure both a responsiveness to local needs and overall coordination for the metropolitan area.

The funding scope of the service access organization includes in-home services and management of the organization's own operating budget.

These are topics that will require further local discussion during the next phase of reform – consultation and planning in Ontario communities. Other topics "For Discussion" appear in following sections.

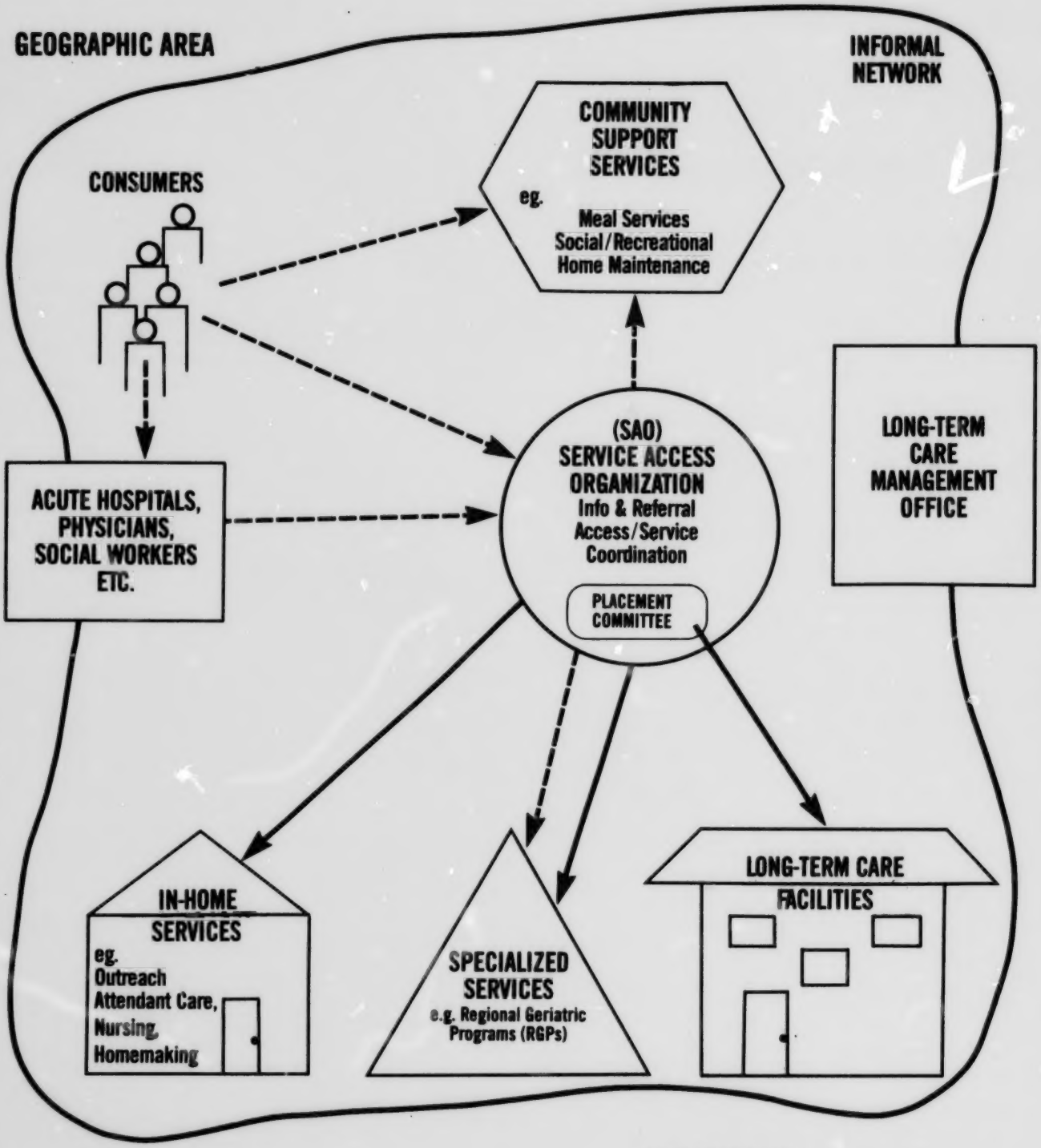
Recommendations for sponsorship of service access organizations based on provincial criteria.

Approaches to testing individualized funding models.

The adaption of service access organizations to geographically large, remote, and densely populated areas.

The relationship between service access organizations and service providers such as: long-term care facilities, the public health services, the acute care hospitals and hospital discharge planners, physicians and specialized services, especially Regional Geriatric Programs.

Reformed Long-Term Care System



Integrate and Consolidate In-Home Services

The existing in-home programs (Home Care, Integrated Homemaker Program, Outreach Attendant Care, Homemakers and Nurses Services, and the Home Support Program homemaking services- will be integrated and consolidated into one unified care and support services program.

A main direction of reform is to develop a responsive, integrated, and manageable range of services to assist people who require personal support and/or professional health-related services in their own homes.

Purpose of Reform

The objective of this consolidation is to design a program that:

- increases the flexibility and responsiveness of services;
- respects the dignity, autonomy, and capabilities of consumers and their families;
- provides consistent eligibility criteria; facilitates self-management of services;
- is cost-effective, efficient, and affordable;
- uses financial and human resources effectively and efficiently; and
- minimizes the number of individuals providing services in the home by consolidating worker functions wherever appropriate.

The program will meet both short-term and long-term service needs. Children will continue to receive necessary personal support and health care in publicly supported school settings so that they may attend school with their peers.

During the development of the in-home services program, advice will be sought from service providers and consumers. Discussions and consultations in local communities will include the roles of various types of service providers in the integrated in-home service program.

Existing services form the foundation of the reformed system.

The Role of In-Home Services

By providing personal support and professional health-related services, in-home services are able to:

- assist people with functional dependencies to participate as fully as possible in community life;
- complement, supplement, and support the efforts of family members and other informal caregivers;
- facilitate early discharge from hospital and prevent unnecessary acute care re-admissions; and
- enable certain children with functional limitations to attend public school with other children.

In-home services include 1) support in the activities of daily living (personal support) and 2) professional health services, teaching, and counselling. These services may be provided by visiting homemakers, respite care workers, attendants, nurses, therapists, nutritionists, other health care professionals, social workers, and volunteers on a visitation basis. Formal in-home services are provided on the basis of determination of an individual's functional abilities and needs. The term "formal" distinguishes these services from the informal help, care, and support that family members, friends, and volunteers provide. Current in-home services are listed in Appendix I.

Reasons for Reform

Existing services form the foundation of the reformed system. Some have served as models for future program design. For example, the Home Care and Integrated Homemaker programs provide a single point of access to certain services in many communities. Outreach Attendant Care is an excellent model for self-managed services.

It is important to recognize the strengths in the existing programs. They have enabled individuals to be discharged early from acute care facilities and

allowed growing numbers of elderly and disabled individuals to reside in their own homes. (The average age of admission to long-term care facilities ten years ago was approximately 75; today it is 85.) Services in the home have focused on maintaining independence, and consumers and informal caregivers have been encouraged to participate in developing a service plan.

A number of problems, however, have emerged in the present system. Some problems related to in-home service provision have been highlighted in recent operational reviews, and others reflect the increasing difficulty in responding to growing demographic and consumer pressures.

Responsibility for delivery of services in the home falls to many agencies. The current administration of in-home services is therefore complex and cumbersome, with over 750 different administering bodies. Comprehensive planning is difficult. Access and eligibility criteria are confusing, and services cannot meet the complex and changing needs of persons requiring personal support and care.

Rigidity in the current system is reflected in service provision rules that sometimes make it difficult for consumers to have their needs met adequately. At present, many individuals with severe physical disabilities must make arrangements with two or more programs to obtain the necessary hours of service that will enable them to reside at home. Individuals may undergo repeated assessments in order to obtain services. Some services, such as nursing, are available during evenings and weekends, but most are available only during weekdays.

Availability of services is variable. In-home and community support services have been expanded periodically during the past two decades. However, further enhancements are required to develop the range and volume of services that would provide alternatives to institutionalization. Rural communities often have difficulty in finding appropriate sponsoring agencies. The Integrated Homemaker Program is available for about one-third of the con-

Increasing numbers of individuals with greater degrees of functional dependency are endeavouring to remain in their own homes but have difficulty in obtaining appropriate services through a fragmented system.

The design of the new in-home services program must ensure that the objective of greater flexibility, and responsiveness to individual needs is achieved.

sumer population. The availability of Home Support services, such as homemaking, varies widely across the province. In redesigning in-home services, increasing the availability of services to reduce the pressures on long-term and acute care facilities is a critical target.

Use of service providers is another factor in the integration and consolidation of in-home services. Provinces that for some time have had programs providing only homemaking, without a requirement for professional services, have developed a pattern of using fewer of the more expensive professional services. A greater use of paraprofessionals to deliver in-home services is likely. However, Ontario is currently experiencing significant problems in retaining homemakers. Although initiatives have begun regarding issues related to wages, benefits, training, supervision, and agency operations, these topics must continue to be addressed.

Considerations for Reform

In planning the reform of in-home services, the following factors must be considered. First, the program will have to meet both short-term and long-term service needs. Second, there must be new criteria to establish eligibility for formal in-home services. Eligibility criteria should incorporate the following features:

- recognition that eligibility for service should be based on "need", not on age, type of physical disability, income, or diagnosis;
- respect for individual autonomy, and consumer and informal caregiver participation in needs identification and service planning;

- recognition of the importance of the roles of informal caregivers and the support services they may require;
- flexibility in individual service planning; prevention of inappropriate or unnecessary use of hospitals and long-term care facilities; and
- recognition of the importance of using human and financial resources carefully and efficiently.

The roles of various types of in-home service providers in the integrated in-home service program.

New eligibility criteria for formal in-home services.

Human resources and training considerations for in-home services.

Self-management of personal support services.

Approaches to ensuring in-home service flexibility and responsiveness to individual needs.

Enhance Community Support Services

A policy framework will be developed for the community support services. Community support services will be enhanced and resources will be targeted to address service gaps and areas of the province which are under-served.

Community support services are a fundamental part of a comprehensive long-term care and support service system. These services have had the responsibility of providing community support to individuals for many years. They must be planned and developed as one of the essential service components of the reformed system.

The Role of Community Support Services

Community support services respond to a broad range of needs and will continue to be directly accessible by consumers rather than through the service access organization described in Strategy #1. The service access organization, however, will have current information on community support services and can refer people to them. Also, the service access organization may purchase services on behalf of some consumers.

Community support services complement both formal in-home services and the informal assistance provided by family and friends. They indicate the richness of support that neighbourhoods and groups are able to generate for members of their community. Some major types of community support services are: meal services, escorted transportation, home maintenance services, non-specialized day programs, health promotion, respite care, social and security checks, Senior Volunteers in Service, Senior Talent Banks and information and referral. (See Appendix I.) These and other services provided primarily by volunteers will become increasingly important as more people remain in their own homes and communities, as longevity increases, and as fewer family members are able to provide support regularly.

Many community-based services rely on the efforts of volunteers, who are essential to service provision now and in the future. Local support and encouragement of volunteerism is an important topic for community consultation and planning.

Reasons for Reform

A number of key issues must be addressed to develop a policy framework for community support services.

Current programs that provide community support services have developed as separate entities. In many cases, each has its own policy, funding, eligibility criteria, and process for determining priorities and expansion. In general, funding arrangements are complex.

These programs, as currently constituted, have not been provided with unified provincial policy guidelines or direction for development. Without an integrating framework or purpose, a number of problems are evident.

- The availability of community support services is uneven particularly in rural and northern areas of the province, and on reserves.
- Local agencies have proliferated, many of them as single-service agencies, which directs resources to administrative costs rather than services.
- Complex funding arrangements have increased competition among agencies and have given an advantage to those that use more than one funding source.
- Consumers may be confused by the multiplicity of agencies, charging policies, eligibility criteria, and lack of coordination between services.
- There is duplication and complexity in administration, and little information exists about the numbers and characteristics of people receiving service.

Community support services complement both formal in-home services and the informal assistance provided by family and friends.

Volunteers have helped make community services viable, and they are essential to service provision now and in the future.

It is also important to recognize these services' "grassroots" nature, flexibility, and responsiveness to local needs.

- It is difficult to assure the quality and effectiveness of programs in a comprehensive way.

These are important factors to consider when integrating and developing community support services in a reformed system. It is also important to recognize these services' "grassroots" nature, flexibility, and responsiveness to local needs. Community support services should not be unduly constrained by regulation or guidelines, but an overall policy framework is needed to give coherence to community planning. A new partnership is needed between community support service providers and government to develop these crucial services in the context of community planning.

Considerations for Reform

Planning community support services should be a function of the community as a whole, rather than of individual organizations, and should include current and potential providers of community support services. Long-term care facilities can be providers of community support services; however, it remains crucial to plan these services in the community context.

It will be necessary to develop guidelines for the expansion of community support services.

It will be necessary to develop guidelines for the expansion of community support services. This work will begin with the assistance of service providers and consumers, and it will continue as an important topic for local discussion. The following criteria should be considered:

- Geographic areas that have few or no community support services should be targeted for development and expansion.
- Priority should be given to services that are in the greatest demand and most limited supply, such as day programs, transportation, and support to volunteers and volunteerism.
- In each community, emphasis should be placed on services that enhance the ability of people to

remain in their own homes and communities and to function as independently as possible.

- Priority should be given to multi-service sponsors, wherever practical. Further, services that demonstrate their willingness to help non-elderly persons with disabilities, as well as elderly persons, should be encouraged.

The ability to monitor utilization patterns, emerging needs, and problems in each geographic area is essential to the effective planning and management of local services.

The development of guidelines for the expansion of community support services, stressing the identification of gaps and under-served areas.

The encouragement of multi-service sponsors for community support services.

The encouragement and support of volunteerism in communities.

Establish an Equitable and Flexible Funding Approach for Community Services

A single local budget will be established to fund community-based services, including the service access organization, community support services, and in-home services. Reliable indicators of the need for personal care and support in the community will be developed as a basis for adjustments to the local community services budget.

A coherent and comprehensive funding approach is required for community support and in-home services. Current inconsistencies, resulting from different funding sources and policies, must be addressed. The funding approach for community-based services must ensure the flexibility to direct resources to priority services, according to local needs.

Design Criteria

The design criteria for a community funding approach must be compatible with the objectives of the reform, and should accomplish the following:

- provide incentives for delivery of high quality services;
- address a "community profile" of needs, recognizing that demographic patterns, and therefore the need for services, vary substantially across Ontario;
- permit flexibility in the allocation and reallocation of resources to meet local and provincial priorities in the context of provincial standards for service;
- address the costs of the service access organization and provide resources to enhance in-home and community support services;
- keep the system as administratively simple as possible, for both government and service providers; and
- assist in controlling cost and ensuring that resources are used effectively.

This approach to establishing a single local budget must address the current differences in funding across the province. It must also reflect the different levels of need for service. A funding policy that uses key indicators of the level of need for community services can be adjusted over time in relation to changes in these indicators.

This approach will permit some flexibility within the allocation for in-home and community support services. Also, it permits a comparison of resource use across the province in relation to the risk indicators for a given population.

Only preliminary work has been done to construct a regional funding approach that incorporates risk indicators and community profiles in Ontario. This aspect of reform that will require further discussion and research in the months ahead.

Implementation of the funding policy will be a responsibility of local offices of the Community Health and Support Services Division, as described in Strategy #9. A local manager, in consultation with local planning groups, will direct resources to the programs and services most in need. To ensure that resources are directed not only to existing services but also to new services, the local management staff will plan with community groups and monitor service priorities in the region.

Funding Specific Community Services

The funding policy described above establishes parameters for allocating provincial resources for in-home and community support services on a regional basis. Further work is needed to determine the appropriate mix of rate-per-service arrangements and program budget arrangements with service providers. An advisory group has been established to assist with design of the new in-home services program. This work will set the direction for more detailed funding policies.

The Current Situation

Currently, community services are funded through contractual arrangements with the local Home Care office, the area office of the Ministry of Community and Social Services, or the municipality. To ensure consistency in dealings with service providers, and to provide fair compensation to homemakers, both ministries have encouraged a reduction in the number of rates paid for homemaker services.

Community services expenditures are now determined by the size of the total provincial allocation, the negotiated budget ceilings for community support services, the Home Care Program regulations and guidelines, and the case management function.

Most jurisdictions with an integrated or single in-home service program control expenditures by establishing clear eligibility rules and by setting limitations on the types of service or the total resources that may be provided to an individual.

Reliable indicators for determination of need for community support and in-home services.

The advantages and disadvantages of various approaches to paying for community and in-home services in terms of their ability to ensure quality service, good administration, and cost control.

Determine the Relationship with Specialized Services

Cooperative work is needed to identify the roles and responsibilities of specialized services in relation to service access organizations, in-home services, community support services, and long-term care facilities.

A comprehensive long-term care and personal support system must use specialized services to meet consumer needs that are particularly complex, severe, and unique. Management of some conditions requires specialized expertise and skilled personnel with levels of training not generally available in generic community services. Specialized services, such as those offered by Regional Geriatric Programs, are designed to restore, improve, and maintain people's ability to function independently, and return to or remain in their own homes for as long as possible.

Overall Role

This work should be undertaken in a spirit that views specialized services playing a critical role in:

- acting as a bridge between acute care hospital services and the community;
- helping restore consumers' functional abilities and enabling them to return to or remain at home;
- providing the expertise upon which other community and facility services may call for consultation, assessment, and assistance with service planning; and
- providing special information and education to consumers, their families and friends, and other service providers.

Ontario has moved toward developing the specialized professional treatment and consultative services essential to the long-term care and support service system. The responsibilities of, and working relationships among, these key service components must be developed to enhance consumer services and staff skills. The planning of long-term care needs to address these roles and responsibilities in greater detail.

Current Specialized Services

Specialized services include specialized assessment, diagnosis, treatment, and rehabilitation. They tend to be used by a relatively small number of persons with unique or complex needs. Current programs that offer specialized services include Regional Geriatric Programs, day hospital programs, Alzheimer's Community Programs, and interpreter and intervenor services for individuals with sensory impairments. (See Appendix I.)

The discussion of the specialized services in this paper is preliminary and does not analyze the role of specialized services in the reformed service system. This area requires further discussion and review.

The roles and responsibilities of specialized services in relation to the reformed service system.

Enhance Support for Informal Caregivers

As part of the reform, support for informal caregivers will be enhanced.

Informal caregiving by family, friends, neighbours, and volunteers provides up to 90% of the assistance required by individuals with functional dependencies. Services that support informal caregivers should be an integral part of the service system and should be enhanced.

As part of the reform, support for informal caregivers will be enhanced in four ways, as described in the following sections.

The Service Access Organization

Family members and friends, on behalf of consumers, often attempt to get information about available services, obtain appropriate services, and interact with a variety of service providers. The new service access organization will simplify this process for informal caregivers by:

- providing information about local services and programs;
- arranging assessment;
- making referrals to community support services;
- providing a single point of access to in-home and long-term care facility services;
- reviewing the needs of informal caregivers;
- involving informal caregivers in service planning; and
- providing service coordination.

Informal caregivers will be able to discuss their ideas, concerns, and needs for support with a consistent contact.

Informal caregivers are family members, friends, and neighbours who provide assistance and support to individuals.

In-Home and Community Support Services

As the current in-home services are integrated and expanded, the needs of informal caregivers can be met more readily. Supports that will be provided through the in-home program include service information, training in specific procedures, counselling, and respite care. There will be a planned expansion of respite services as part of the enhancement of support for caregivers. Many community agencies provide information and support groups for informal caregivers. A policy framework for community support services, as described in Strategy #3, will be developed to enhance supportive services offered by community agencies.

Informal Caregivers – Who are They?

Informal caregivers are family members, friends, and neighbours who provide assistance and support to individuals. Their help ranges from advice to supervision to personal care. Estimates suggest that 80% to 90% of the help provided to people who need personal support or assistance with daily living comes from friends and family.

The informal caregiver often resides in the same household as the individual who requires assistance. In some cases, however, the caregiver regularly visits an individual who lives alone or in a residential setting. When an individual resides in a long-term care facility, informal caregivers may continue to provide assistance and they may require support services.

Most individuals with physical disabilities receive some support from family members; however, increasingly more adults with physical disabilities (as well as elderly persons) prefer not to depend on family members for assistance.

Middle-aged women are frequently primary caregivers and may be responsible for the care and supervision of a child, a physically disabled spouse, and/or aging parents. Since men have tended to marry women younger than themselves, wives are more frequently involved in the care of their aging or ill spouses than are husbands. Because of increasing longevity, a daughter in her seventies may now be caring for a parent in his or her nineties.

To a large extent, informal caregiving is provided by women.

The Role of Informal Caregivers

Informal care includes a vast range of activities. It may mean being a friend or advocate. It may involve obtaining information on services or providing advice on financial or legal matters. Some informal caregivers provide housekeeping, transportation, child care, or respite care. Others are involved in supervising, providing personal care, administering medications and performing technical procedures.

Unlike most formal services, informal caregivers provide assistance at night, during weekends, and on demand.

The support they give is individualized and flexible, and it changes as the person's health changes. Formal services can assist the individual with the activities of daily living but cannot replace the fundamental role of friends and family.

Types of Support Services for Caregivers

Informal caregivers, regardless of the amount of care they provide or their relationship to the individual, often need help to continue their supportive role. Services provided in the home or community that assist consumers usually assist their informal caregivers as well. In addition, there are support services, such as counselling, peer support, and respite care, that are designed specifically for informal caregivers.

Respite services, or caregiver relief services, allow opportunities for the family member or friend to rest, shop, vacation, or spend time with other members of the family. They offer physical and emotional

relief from caregiving duties, and provide care for the consumer, usually on a preplanned, but sometimes on an emergency basis.

Adult day programs involve elderly persons in activities during part of the day, providing some caregiver relief. Other community models include respite cooperatives and host family models.

During community planning, discussion needs to occur regarding the appropriate use of long-term care facilities for emergency respite care and for preplanned arrangements when individuals cannot be cared for on a full-time basis in their own homes.

Respite care is a critical form of support for caregivers, but it is not the only assistance available. **Information services and support groups** are offered by a variety of community agencies, and groups. They provide information on services and resources, as well as legal and financial advice. In addition, **self-help groups** may be set up to share problems and experiences, and provide assistance, for example, in dealing with friends or relatives who have certain conditions or diseases.

Additional Considerations

The provision of some support services beyond current program times should be considered. This will not only allow caregivers to pursue employment or educational opportunities, but also give them some assistance during the evening or night.

Information on support services must be widely available. Many caregivers, especially spouses unaware of available services, continue to provide care under deteriorating conditions, until a crisis makes immediate institutional placement necessary.

The strain of caring for persons with dementia at home is a major factor in requests for long-term care facility placement. Round-the-clock supervision may be required. In order to maintain these individuals at home for as long as possible, caregivers may need considerable support to continue their role.

The design of caregiver relief programs should incorporate information on the physical conditions that require specialized care, for example, on caring for individuals with complex medical needs.

The role of community organizations and programs in providing support for informal caregivers.

The appropriate use of long-term care facilities for emergency respite and periodic care.

The development of alternative, innovative community support services for informal caregivers.

The early identification of caregiver needs and ways of informing caregivers about available supports.

Reform Policies for Long-Term Care Facilities

Coordinated policies for nursing homes, homes for the aged, and chronic care resources will be developed to enable these facilities to serve a changing population.

Long-term care facilities have been and will continue to be an integral part of the long-term care and support service system. Traditionally, nursing homes, homes for the aged, and chronic care facilities have served consumers who could not have their needs met adequately or safely in their own homes and communities. As opportunities for community living have expanded, long-term care facilities have been called upon to provide care for individuals with more complex needs. They have met this challenge.

All service sectors strongly agree that a comprehensive system of in-home and community support services must be developed, and that long-term care facilities will increasingly serve consumers with a greater need for heavy and complex care. In order to support properly the facilities in this vital role, provincial policies governing them must be reformed to keep pace with changing public expectations.

Overall growth of Ontario's long-term care facilities is not envisaged in the immediate future. The priorities of reform for long-term care facilities are to ensure that the existing bed supply is used as effectively as possible and to strengthen the capability of facilities to serve a population with changing needs.

Coordinated policies for nursing homes, homes for the aged, and chronic care resources will be developed to enable these facilities to serve a changing population.

Elements of the Reform Strategy

This strategy includes the following elements:

- Coordinate and manage access to long-term care facilities through the service access organization.
- Introduce a funding policy for nursing homes and homes for the aged that recognizes the care needs of residents.
- Introduce a classification system that reliably measures the care requirements of facility residents.
- Establish consistent accountability standards for nursing homes and homes for the aged.
- Develop updated and consistent program standards for nursing homes and homes for the aged.
- Review the role and responsibilities of chronic care.

Long-term care facilities often support or provide community services. For example, they may supply meals for individuals living in the community, sponsor a day program, or provide respite care. This support role will be planned locally in conjunction with other community services.

For residents and their families, these new directions for long-term care facilities will reduce the confusion about access, set priorities based on individual needs, and increase the quality and accountability in service provision.

For acute care hospitals, these reforms will help to direct people needing heavy care to appropriate community facilities, and reduce the pressure on acute care beds.

The directions for long-term care facilities are discussed below in detail.

Admission to long-term care facilities should be limited to people who cannot return to or remain in their own homes or communities.

Coordinate and manage access to long-term care facilities through the service access organization.

This approach builds on the success and experience of Placement Coordination Services in assisting families and service providers. Admission to long-term care facilities should be limited to people who cannot return to or remain in their own homes or communities. In other words, facility services will serve those who require a type or amount of service that cannot be delivered at home because the combined efforts of informal helpers and formal services cannot ensure the consumer's safety.

In situations where the number of beds is limited, this approach permits the priority of access to facilities to be determined by the urgency of the consumer's situation. Also, it enables community services to direct extra help to people awaiting placement in a facility.

The facility placement committee, and its role and responsibility in relation to the other service components, are described in Strategy #1. This committee will play a critical role in managing access and setting priorities for access to facilities. Service coordination will provide an important connection between the community and facility services.

A clear implication of this strategy is that the current distinction between "residential care" and "extended care" will disappear. Access to facilities will be planned for persons who require placement.

Introduce a funding policy for homes for the aged and nursing homes that recognizes the care needs of residents.

Current funding arrangements for long-term care facilities have been designed for each type of facility. The design criteria for a new funding approach must reinforce the objectives of reform and should:

- provide incentives for delivery of high quality services;

- recognize the changing care requirements of residents over time;
- provide incentives for cost control in both for-profit and not-for-profit settings;
- determine reimbursement levels by a rational and administratively simple means, based on level of care provided;
- ensure that resources are directed to resident care; and
- be as administratively simple as possible for both service providers and the government.

Long-term care facilities will be funded on the basis of per diem rates that incorporate nursing and personal care, program, and accommodation costs. Facilities will be reimbursed for the expenditures they incur, up to an established ceiling for nursing and personal care and program costs. They will be allocated a flat rate for accommodation ("room-and-board") costs and permitted to retain operating surpluses in this portion of the budget, provided they meet the standards set by the province.

Long-term care facilities will be funded on the basis of per diem rates that incorporate nursing and personal care, program, and accommodation costs.

The nursing and personal care part of the budget incorporates nursing and other staff care. The program category includes therapy, counselling, and activation. The accommodation costs include facility administration and maintenance, dietary and housekeeping categories.

The "nursing and personal care" part of the funding model includes a separate budget for each facility that recognizes the amounts of care that various residents need and enables facilities to accept and provide care to people whose needs are greatest. This approach requires a classification system that reliably identifies the resources required to provide a basic standard of care for various needs. The mix of care levels provided by each facility will be used to construct a unique personal care budget for each operation. Within that budget, the facility will be reimbursed for expenditures up to the total allocated for personal care.

The mix of care levels provided by each facility will be used to construct a unique personal care budget for each operation.

This component comprises both direct nursing and personal support services, e.g. time spent in actually caring for the client, and indirect costs, e.g. charting, medication preparation.

The key features of funding direct nursing and personal care in this way are:

- funds to facilities for direct nursing and personal care will depend upon the service requirements of residents in that facility;
- on a province-wide basis, budget increases for nursing and personal direct care will be allocated to providers using a level of care classification system;
- operators must demonstrate that the money has been spent on nursing and personal care in order to be reimbursed for the costs.

"**Program**", the second component of the proposed funding model, includes services such as social work, rehabilitation, counselling, recreation, and pastoral care. A consistent per diem allocation for these services will be provided to each facility. The facility will be reimbursed for its actual expenditures up to the allocated budget.

The funding level for program support will cover average levels of programming.

The funding level for program support will cover average levels of programming. Should the government decide to enhance funding to cover the specialized programs provided by some facilities, for example, for individuals with dementias, it may be necessary to review funding levels on a program-by-program basis, to ensure the appropriateness of resource allocation. In these cases, the specialized programming will be funded as a separately negotiated item.

"**Accommodation**" costs, which relate to dietary, housekeeping, laundry, building maintenance, and administration, account for the remainder of the budget.

Unlike the nursing and personal care and program components of the budget, accommodation services are "fixed". Although the operator will be required to

account for expenditures, this is the part of the budget in which efficiencies may be achieved. Facilities may generate a surplus in this area, provided they maintain provincial standards of service and operation.

For accommodation services, a standard and fixed per diem amount will be allocated to all facilities. The exception is "raw food" costs, which will be funded up to a predetermined limit. Marginal adjustments may be made to reflect facility size in this component of the budget. Facilities must demonstrate that the allocated budget for food is actually spent for food, and they will be reimbursed for the costs up to the budgeted or actual amount.

For accommodation services, a standard and fixed per diem amount will be allocated to all facilities.

The funding of long-term care facilities currently includes important **contributions by municipalities and charitable organizations**. *The funding model described above does not exclude such contributions or other contributions to proprietary facilities.* These additional contributions are encouraged and will be essential for many facilities, given their current levels of expenditures. *The funding policy is meant to establish a new basis for the provincial funding of long-term care facilities and to ensure that basic standards of service and care are commensurate with available resources.*

To enable facilities to adapt their budgets and funding levels, an adjustment policy will be negotiated with the affected organizations.

The new funding model departs from the current funding approaches for homes for the aged by not including a prescribed formula for sharing operating deficits between the province and the municipality or charitable organization responsible for the facility. This policy shift will require an adjustment period for a number of facilities, depending on their current budgets, their resident mix, and the establishment of new per diem rates. To enable facilities to adapt their budgets and funding levels, an adjustment policy will be negotiated with the affected organizations.

This funding approach requires a validated, reliable way to classify residents' care requirements.

Introduce a classification system that reliably measures the requirements of residents in all facilities.

The new funding model establishes a direct link between the residents' nursing and personal care requirements and the funding of facilities. To a larger degree, this approach eliminates current distinctions between categories of beds and categories of facilities. It will enable facilities to accept and care for people with heavier care requirements. With changes over time in a facility's resident mix, funding may be adjusted to reflect the changed need for resources.

This funding approach requires a validated, reliable way to classify residents' care requirements. An extensive review of relevant classification systems has been conducted. It concentrated on systems used in other Canadian provinces and in the United States, where substantial research has been conducted on issues related to facility funding.

The classification systems used in these jurisdictions were assessed using a variety of criteria, including: reliability; validity; comprehensiveness of item, content, and coverage; rigorous field testing; objectivity; availability of data; ease of administration; and usefulness as a basis for funding. The Alberta Patient Classification System, which meets these criteria, has been selected for adaptation in Ontario.

In August 1989, ten Ontario facilities participated in a feasibility test of the Alberta Patient Classification System. They included a chronic care hospital, nursing homes, and homes for the aged, in both urban and rural communities. These facilities were an "opportunity sample" of facilities that agreed to assist the reform initiative and were only partially representative of the province as a whole. Nevertheless, the resulting information was very useful in confirming the selection of the Alberta instrument. Further testing of the model will be undertaken prior to its implementation to determine what additional modifications are required.

It should be emphasized that the level of care classification system will be used for funding purposes only.

It should be emphasized that the level of care classification system will be used for funding purposes only. It will be used to determine how the available nursing and personal care resources will be allocated to various facilities. *It does not determine who should be admitted to a facility, nor does it form the basis for planning the care of individual residents.* It will establish for each facility a unique resident-mix index, which in turn will affect the amount of nursing and personal care resources the facility needs and will receive.

Other policy changes will be needed to enable facilities to serve individuals who require greater amounts or different types of care. For example, homes for the aged and nursing homes may not be equipped or permitted, given current outdated policies, to care for some residents. These policy changes must be addressed in order to realize the advantages of a more flexible funding policy.

To implement a provincial resident classification system in Ontario, people with "hands-on" experience in long-term care facilities must be involved in the planning efforts. An advisory group, including individuals with knowledge and experience in this field, has been established to guide the adaptation of a resident-needs classification system for Ontario.

Establish consistent accountability standards for nursing homes and homes for the aged.

Integrating the planning and responsibility for long-term care facilities also means that the accountability for service providers and the resources used must be addressed in a consistent manner. Placing responsibility for the system within a unified management structure will ensure a single standard of service and a single, coordinated approach to accountability for nursing homes and homes for the aged.

Current legislation governing long-term care facilities has various standards and expectations for service and various means of encouraging or enforcing

Placing responsibility for the system within a unified management structure will ensure a single standard of service and a single, coordinated approach to accountability for nursing homes and homes for the aged.

There will continue to be a mix of for-profit and not-for-profit providers of long-term care services. Both for-profit and not-for-profit providers should be involved in local planning activities.

compliance among municipal and charitable homes for the aged and nursing homes. The accountability framework should encompass a single standard of service for all residents of nursing homes and homes for the aged. Individuals must be assured of a basic standard of service and quality of care, regardless of the location or type of bed.

Accountability mechanisms will be designed to ensure that clearly defined service standards are achieved. Systems must be in place to support and encourage the achievement of these standards, to monitor their accomplishment, and to enforce them through sanctions, if necessary.

Wherever possible, accountability mechanisms should use incentives and remove disincentives to encourage quality service. The approach to accountability should enable and reward the creative, cost-effective management of long-term care services. The greater the spending controls, the less need to rely on inspections and standards for accountability.

There will continue to be a mix of for-profit and not-for-profit providers of long-term care services. Both for-profit and not-for-profit providers should be involved in local planning activities.

The province will retain its authority to allocate and distribute beds in a planned, fair, and equitable manner. It will approve homes for the provision of services and determine the duration of approval to operate. It will set standards and monitor compliance for ongoing approval to operate and protect the public interest, which involves full public accountability and financial disclosure.

Develop updated program standards for nursing homes and homes for the aged.

Programming in nursing homes and homes for the aged has to be considered in view of the changing consumer group and the complementary changes to policies required to support the introduction of level of care funding.

For example, current restrictions on service may be outdated in view of level of care funding and the need for a substantially increased capacity to provide heavy care and palliative care in nursing homes and homes for the aged. Program models need to be developed for respite care, convalescent and short-stay programming.

Review the role and responsibilities of chronic care

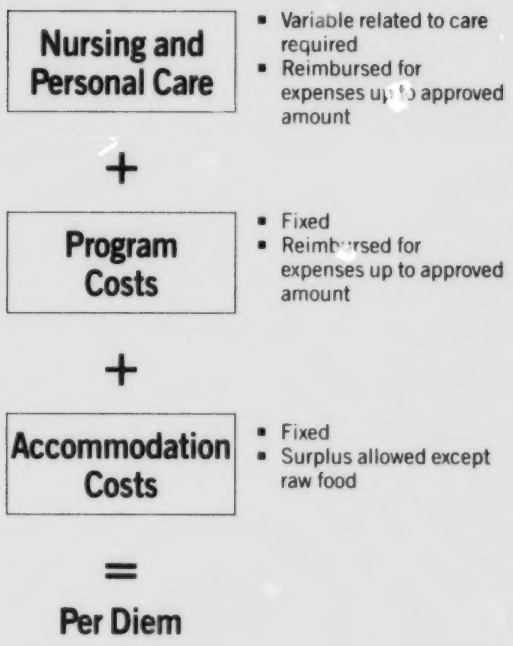
As the capacity of community services, nursing homes, and homes for the aged increases, the role of chronic units and hospitals in relation to long-term and acute care services must be reviewed. In the next phase of reform, a study of the current role and planning for the future role of chronic care will be undertaken. An advisory group will address such issues as the services provided in chronic care settings, the special nature of hospital-based long-term care, the types of consumers who will need to be served in chronic hospitals, and the types of consumers who can be served in other settings. This work is necessary before chronic care funding reform can be considered.

Reasons for Reform

Ontario's long-term care facilities have been operating under differing policies and legislative bases. The reform strategies are designed to coordinate the facilities' planning, policy, and funding in order to enable them to function more effectively and provide solutions to the following problems:

1. The separate ministerial responsibilities for long-term care facilities have inhibited comprehensive planning and policy. Funding for each program is negotiated separately with the responsible ministry. This does not necessarily provide a view of overall community needs or enable a calculation of the impact of a funding policy or decision in one program on other aspects of the system. This difficulty is being ad-

Facility Funding Model



dressed through a new, integrated health and social services division, described later in this paper.

2. At present, access to facilities may be assisted by the Placement Coordination Services or depend on referral by family members and the family physician. This may be confusing for consumers and their families.
3. Current funding arrangements, based on bed designation rather than the needs of residents, have contributed to the inefficient use of long-term care beds and inappropriate use of acute care beds.
4. Different resident contributions exist for facilities' extended care and residential care services, and this is confusing for residents.
5. Restrictive and outdated program policies contribute to difficulties in finding placement for individuals who require certain types of services; for example, homes for the aged are prohibited from admitting persons who require catheterization or pressurized oxygen.
6. Different program standards and approaches to accountability have evolved.

Linkages between long-term care facilities and community-based services.

Linkages between long-term care facilities and service coordinators.

Linkages between long-term care facilities and acute care hospitals.

The level of care classification system and its implementation in Ontario's long-term care facilities.

Program models for respite care, convalescent and short-stay programming, and for community support services offered by facilities and planned in the community context.

Introduce a Balanced Co-Payment Policy

A balanced co-payment policy that enables consumers and the government to share the cost of services equitably will be introduced. The principle of affordability will apply for all who use the long-term care and support services system.

The current long-term care services include a variety of direct charges to consumers. Like the programs, these charges have evolved over years with differing policies and legislation. Review of these charging policies reveals their inconsistencies among services and programs.

The reform of long-term care is an opportunity to develop a consumer charging policy that is both compatible with service objectives and contributes to the cost of providing services. People will continue to pay all or part of the cost of some services. Those who cannot afford to pay, however, will not be required to pay any portion of the cost of services they receive.

Design Criteria

The costs of long-term care will continue to rise with changing trends and increasing population. There will always be competition for resources among the human services, and between these and other areas of public spending. *An affordable long-term care system will share the costs of services among levels of government and consumers.* It will use resources effectively to enable people to remain in their homes and communities when possible and to receive care

There will be no charges for treatment or personal care services.

in facilities when necessary. *There will be no charges, however, for treatment or personal care services.*

The specific criteria for a charging policy compatible with the reform objectives are:

- to promote a consistent and equitable approach to charging for community, in-home, and facility services;
- to help pay the cost of services provided;
- to be affordable to consumers and sensitive to the possible accumulation of charges; and
- to be administratively simple.

The consumer co-payment policy will balance these criteria. It will maintain or achieve consistency across facility and community-based services, and will remove incentives to use higher-cost services when they are not required.

The charging policy will move from charges specific to different programs to charges related to types of service, in order to establish a systematic and consistent approach. A basic principle of implementation will be ability to pay.

Co-Payment in Facilities

The current differences in co-payments between residential care and extended care will gradually be eliminated. Each resident will pay a co-payment that more accurately reflects the accommodation ("room and board") part of a facility rate. Accommodation covers the cost of maintaining and administering the facility, food and its preparation, laundry services, and housekeeping. There will not be consumer charges for nursing and personal care services or facility program components such as social work, rehabilitation, counselling, recreation, and pastoral care.

The assessment of consumers' ability to pay must be based on their income and assets. Some will be able to afford the total charge; others will pay only part of the charge, depending on their ability to pay. Each resident will continue to have a disposable income for personal needs.

The new co-payment policy for facility residents will be implemented when the new funding model and budgeting system are introduced into facilities. A gradual conversion will occur.

At present, facilities that provide residential care are responsible for assessing people's ability to pay for service. This experience will be used to devise an implementation approach that is as simple as possible.

Co-Payments in Community-Based Services

The charging policy for community services will be consistent with the facility co-payment policy. Consumers will be charged, according to ability to pay, for services such as cleaning, cooking, laundry, shopping, home maintenance, and meal services.

Services provided in the home may include treatment, usually provided by nurses and therapists, and personal support and care, provided by a variety of workers. Assistance with bathing, eating, and toileting is considered in both community and facility services to be a "personal support and care" function. There will be no consumer charge for treatment or personal support and care services.

Consumers' ability to pay will be assessed on the basis of income, not assets. The method of estimating an individual's ability to pay and the level of charges that he or she will contribute, must take into account the need for multiple services and other demands on the person's income. There should not be an unreasonable multiplicity of charges.

At present community support services are subject to diverse and varying charges. The charging policy and the amounts charged to individuals are matters for community support agencies to decide. A consistent charging policy will require these various approaches eventually to be coordinated with the overall policy for consumer charges.

At present community support services are subject to diverse and varying charges.

Consumers will be charged for community support services on a sliding scale with monthly caps on charges related to income. Individuals with net incomes of approximately $20,000 or less will not be charged for services. Those with incomes over $20,000 will pay a gradually-increasing portion of service costs. Only individuals with net income over $50,000 will be expected to pay the full cost of services such as cleaning, cooking, home maintenance and meals.

Reasons for Reform

Like the long-term care programs themselves, the current approach to service charges has developed without reference to an overall system or to the relationships among various services. The current charging policies are not consistent and do not reinforce the objectives of a coherent, integrated service system.

Charges for facility service vary in both approach and rationale. Residential care is needs/asset-tested and charges are based on the consumer's ability to pay. The extended care charge is a flat rate tied to a minimum income guarantee. While the charge for residential care is associated with the total cost of service, the charge for extended care is not related to service but geared to the minimum amount of an individual's income.

Since the current co-payment is not directly related to the cost of services, residents and their families may be unaware of increases in actual costs over time and of the cost of facility services relative to in-home and community services. In addition, the present co-payment does not recognize increasing demands on facilities due to demographic changes or changes in income of the elderly population.

Charges for in-home and community support services have similar discrepancies. They may be applied inconsistently. For example, homemaker services are free to the consumer if provided under the Home Care program, but require a needs test if provided

through the Homemaker and Nurses Services program. Also, charging policies vary among agencies that provide Home Support services. Thus, the same or similar services may be offered for different charges or no charge, depending on provincial and agency-determined charging policies.

Consumers may not be aware of the actual costs of the services they receive. Wage improvements for workers providing services in the home and the anticipated increase in the number of consumers receiving in-home services will increase the pressure on resources and service costs.

Summary

Wherever they reside, people are responsible for paying their own basic living and household maintenance costs. The new co-payment policy incorporates that responsibility. If people who can afford to help pay for services do not do so, eventually there will be less service available for those who need it. The co-payment policy, while recognizing that obligation, also recognizes the differing abilities of people to pay for services, and seeks to ensure that consumer co-payments are implemented fairly and that service provision is the first priority. In other words, the new policy addresses the high cost of services while ensuring that people who need those services receive them, whether or not they can afford to pay.

The process of assessing consumers' ability to pay for support services.

Part III:
Strategies for Management of the System

Establish an Integrated and Decentralized Management Structure

An integrated and decentralized division of the Ministries of Community and Social Services and Health will be established to plan reform with communities and to manage the long-term care services system.

A Community Health and Support Services Division has been established. It combines programs of the Ministries of Health and Community and Social Services. This joint structure merges the long-term care and support services with the community health services.

Role of the New Management Structure

The division will manage policy development for the reform and will continue the program management of community health services. Two branches will manage the operational aspects of the long-term care system. One branch is responsible for residential services; the other for in-home services. Over time, these centralized functions will be transferred to the local offices.

The new division is establishing fourteen local offices, where management staff will work cooperatively with local organizations and the district health councils to plan the implementation of comprehensive reform. The local offices will be responsible for program coordination, financial management, and service monitoring.

Because the two ministries now have different structures and ways of relating to organizations, service providers may expect a period of transition and adjustment. This period will require service providers to deal constructively with each other as well as with ministry authorities. Every effort will be made to reinforce the new structure and to encourage local planning and system reform to occur in cooperation with the new local offices. The new division will ensure that, during the transition, priority is given to coordination and communication, and that service delivery is not interrupted.

The decision to establish a joint structure reflects the importance to the provincial government of a coherent community care and personal support system and the values inherent in the reform.

Assistant Deputy Minister
Community Health and
Support Services Division

Executive Director Community Health	Director Policy	Executive Director Support Services
▪ public health	▪ long-term care and support services	▪ residential services
▪ community mental health		▪ in-home services
▪ health promotion		▪ fourteen local offices
▪ community health		

The decision to establish a joint structure reflects the importance to the provincial government of a coherent community care and personal support system and the values inherent in the reform. It confirms the determination to provide coordinated leadership for the reform initiative. This approach is intended to integrate the two ministries community health, personal assistance, and community support resources and programs, while maintaining strong links with community agencies, hospitals, and other service organizations. The strategy recognizes the many integral connections between health and social service systems and policies.

The decentralized management system is intended to maximize local problem-solving and coordination, in the hope that reform will build upon the unique array of agencies and relationships in each Ontario community. The provincial government is interested in moving toward a greater local management of human services. It recognizes, however, that policy and program reform of long-term care is necessary before responsibility can be transferred to the local level of authority.

Ensure Community Involvement in Planning Services

Substantial community involvement in planning services, in determining the future interrelationships of service providers and in setting priorities for local implementation, will be required.

One important question addressed in discussions with community groups during the summer of 1989 was how community participants might help to plan the implementation of reform.

Local Planning Groups

Among the organizations currently involved in local planning are the district health councils, Ministry of Community and Social Services area offices, municipalities, social planning councils, interagency councils, service-providing organizations and consumer groups. All of these were seen as continuing and active participants in the community planning process for long-term care reform.

Planning needs a local structure and focus. However, that focus and the nature of the planning process must be cooperatively determined at the local level. They will necessarily vary from area to area, as circumstances dictate. As a basic guideline, therefore, planning should build on the successful endeavours and strengths of existing local planning bodies. Given the breadth of reform, it is also essential that a variety of service providers and consumers participate in local reform.

District Health Councils

District health councils are important participants in the planning of health services. They advise the Minister of Health in planning and developing integrated systems of health care services in their catchment area. An enhanced role for district health councils has been approved, which includes:

- a continued advisory role in the allocation of funds, expanded to include advice on capital and the reallocation of existing funds;
- the identification of human resource requirements for local health services;

- the strengthening of area-wide planning (beyond individual district boundaries); and
- the integration of health and social service planning and the exploration of ways to co-ordinate local service delivery.

Municipalities

The relationship of municipalities and the Ministry of Community and Social Services has been analysed extensively over the past several years through the Provincial Municipal Social Services Review. A significant aspect of this review is the continuing constructive discussion between partners to clarify their roles and responsibilities with respect to social services.

The report of the Provincial Municipal Social Services Review was released in April 1990. During consultations on that document and on long-term care reform, it will be necessary to address the options around responsibility for service system management planning and funding for long-term care and personal support services. Dialogue with municipal partners will continue to clarify the roles in and responsibilities for the provision of health and social services.

Service Providers

Service providers in many communities are actively engaged in local service planning. Guidance for this work may be provided by an interagency council, a social planning council, a district health council, or a special committee or task force. The planning of local long-term care reform will engage service organizations in various forums and cooperation among partners will be essential to the reform's success.

Consumers

To date, the dialogues on long-term care reform have involved service consumers as well as service providers. The perspective and concerns of individuals who use personal support and long-term care services are essential to planning reform at the local level. The local planning process should actively seek consumer involvement.

Implications for Human Resources

There will be a greater demand for personnel and the need for training and educational strategies to meet that demand.

Two aspects of the comprehensive reform have major implications for human resources planning. First, in-home and community support services will receive increased emphasis. Second, long-term care facilities will be providing services to people who have increasingly greater care requirements. As a result, there will be a greater demand for personnel and the need for training and educational strategies to meet that demand.

As the reform proceeds, there must be further discussion and planning to meet this challenge. The issues and potential strategies described below are preliminary thinking in this area.

Availability of Professionals

At present, it is difficult to recruit and retain adequate numbers of appropriately trained professionals to provide in-home services. New approaches to recruitment and retention must be explored.

The changing and pivotal role of in-home services will, in many instances, demand the skills of professionals to assist in assessment and service planning. Currently, these functions are usually performed by nurses. It is anticipated that other professionals, such as physiotherapists, occupational therapists, and social workers, will have an increasing role in community service teams. Furthermore, the role of the registered nurse may change, with greater emphasis on assessment, planning, supervision, and provision of specialized care. At the same time, there is a need to re-evaluate in-home nursing services to determine the ways in which registered nursing assistants and trained attendants could assume a greater role.

As a result of the increased service requirements of residents in long-term care facilities, staffing requirements will increase, in terms of both numbers of staff and skill levels. Again, greater use will need to be made of registered nursing assistants, attendants, and aides. Attention must be paid, however, to making consulting services available for staff dealing with residents who have complex care requirements.

The Report of the Joint Working Group on Rehabilitation Manpower discussed ways to increase the number of physiotherapists, occupational therapists, speech and language pathologists, and audiologists. Supported by the federal/provincial Committee on Human Health Resources, representatives of the national professional associations have developed a discussion paper on the role and use of auxiliary personnel in rehabilitation. They support the use of discipline-specific auxiliaries who would be trained on the job and work under the direct supervision of professionals.

Homemaker Wages

Low homemaker wages have a direct bearing on the availability of this vital group of workers. It is well recognized that the wages, working conditions, and training of homemakers must be improved if service demands are to be met and if trained workers are envisaged for the future.

Homemaker / Attendant / Support Worker Training

Most homemakers are not trained before being hired by an agency. Under the regulations to the *Homemakers and Nurses Services Act,* almost anyone with experience in household management can be considered qualified to work as a homemaker. When a homemaker is hired by an agency, her or his training consists primarily of on-the-job orientation. The *Report of the Interministerial Committee on Visiting Homemaker Services* recommended that there be a phased-in requirement that all homemakers complete the Home Support Level II course or equivalent.

A potential difficulty in attempting to standardize training is that many consumers train their attendants themselves, in accordance with the consumers' own needs and schedules. Some people with a physical disability have expressed the concern that the proposed training program might lead to over-professionalization and a medically oriented model of care rather than a support service model. They point out that most attendants work part-time while, for example, attending university courses in an unrelated field. In such cases, it is unlikely that these people would want to take a community college course to receive qualifications.

Health Professions Legislation Review

New health disciplines legislation, currently being developed by the Health Professions Legislation Review (HPLR), will define in some detail the functions that are to be designated as licensed health care procedures, or "acts", which must be performed by particular health disciplines. This new approach holds significant implications for many of the health disciplines and for the provision of attendant services.

At present, attendants may perform procedures that HPLR has designated as health acts that must be carried out by specific health professionals. This problem has been recognized, and measures allowing attendants to continue to provide appropriate services are being developed. The intention is to ensure that changes to health professions legislation do not interfere with the desire of people with functional dependencies for greater independence.

Community Emphasis in Educational Programs

The enhancement of community support and in-home services requires a greater emphasis on community applications and experience in all training programs. In the future, many more direct service providers will work in community settings and in people's homes. Recognition of and appropriate training for this reality is required.

In the future, many more direct service providers will work in community settings and in people's homes.

Legislation

Initial legislation will be introduced.

The reform of long-term care affects many statutes and regulations currently administered either by the Ministry of Health or the Ministry of Community and Social Services.

The statutes include the *Nursing Homes Act*, the *Homes for the Aged and Rest Homes Act*, the *Charitable Institutions Act*, the *Health Facilities Special Orders Act*, the *Homemakers and Nurses Services Act*, the *Health Insurance Act*, and the *Elderly Persons Centres Act*.

Changes Required

Some aspects of long-term care reform can be implemented without changing existing legislation. Other aspects, however, conflict with or are inconsistent with present legislation and will require its amendment. Still other aspects of reform will require new legislation to provide authority for implementing service changes. In addition, some services currently funded and operated under the authority of the *Ministry of Community and Social Services Act* are affected (for example, Home Support and Outreach Attendant Care). It is now time to draft appropriate legislation to govern the operation of these services.

Prior to legislative reform, changes to the long-term care system will be implemented, where possible, under existing legislation, including the *Ministry of Community and Social Services Act* and the *Ministry of Health Act*.

The definition, design, and refinement of the whole service system will take some time to complete, and implementation will proceed in stages. Therefore, legislative reform will occur in two steps.

Initial legislation will be introduced to enable the implementation of many critical elements of long-term care reform, while permitting the flexibility needed to implement a new system. Current plans are that a bill will be introduced in the legislature by the spring of 1991. It will contain a section that will limit the life of the statute.

Subsequent legislation will create a single comprehensive statute to govern the whole long-term care system and its service elements. It will respond to the role study of chronic care units and hospitals and reflect the results of further policy work and initial experiences with the implementation of a new system.

Subsequent legislation will create a single comprehensive statute.

Contents of Legislation

The contents of both the initial legislation and the subsequent comprehensive legislation will depend on policy decisions made during developmental work and in the light of experience with the new system.

The initial legislation will deal with service access organizations and their facility placement committees, long-term care facility services (specifically, nursing homes and municipal and charitable homes for the aged), and the new, consolidated in-home services program. It will contain sections concerning the following aspects of reform:

- statement of purpose or declaration of principle to guide the operation of services and the interpretation and implementation of the legislation and regulations;
- management responsibilities and the delegation of powers in the system, which may include sections concerning responsibilities for administering and enforcing aspects of the legislation, (for example, licensing facilities, approving budgets) and concerning the delegation of responsibilities (for example, to program supervisors and inspectors);

- the accountability of service providers, which may include sections specifying powers of inspection, financial reporting requirements, and powers to revoke licences and approvals;
- the role and authority of service access organizations and of facility placement committees, which may include sections on the appointment of facility placement committees and their role in admissions to long-term care facilities;
- funding authority, which may include sections on operating and, where appropriate, capital funding for service access organizations, long-term care facilities, and in-home and community support services;
- the rights of and protections for consumers and residents, which may include a bill of rights for all facility residents; and
- regulation-making authority, which may include authority to deal more specifically with any of the above topics.

In summary, the initial legislation will provide the mandate, funding, and governance for the new consolidated in-home services and for service access organizations and their facility placement committees. It will also provide a consistent and unified system of accountability and administration for nursing homes and homes for the aged and will make funding reform possible.

Part IV: Next Steps

Part IV: Next Steps

This paper is intended to provide a focus for the next phase of the reform: a community discussion process that will review strategic directions, resolve concerns, build partnerships, and begin the local implementation planning process.

The preceding sections of the paper have outlined the rationale and strategic directions for the reform of long-term care and the Ontario government's intention to develop a coherent, integrated service system. The next steps in the reform are community consultation and implementation planning.

Community Consultation

Initial discussions on the directions that reform should take have included meetings in sixteen communities across the province as well as meetings with many provincial organizations and groups. In addition, two advisory structures are being established: an advisory group on program design to work with the provincial task force and a broad-based provincial reference group, to bring its experience and problem-solving skills to the reform process.

This paper is intended to provide a focus for the next phase of the reform: a community discussion process that will review strategic directions, resolve concerns, build partnerships, and begin the local implementation planning process. Community consultation will be coordinated by the new local managers of the Community Health and Support Services Division in partnership with existing planning bodies, such as the district health councils, municipalities, and Ministry of Community and Social Services area offices. This process will include:

- a series of information meetings for consumers, service providers, and informal caregivers;
- issue-oriented local meetings for consumer groups, service providers, informal caregivers, Aboriginal peoples, francophone communities, and other stakeholders in the reform;
- the establishment of a community planning process as the focus for discussing, planning, and resolving local issues;
- the development of community plans to implement the reform.

A news bulletin will be published regularly to provide program and administrative information and to enable communities to share experiences relating to the reform process. A resource centre in the new division will be established to ensure that current and consistent information about the reform is available. Meetings and discussions with provincial groups and organizations will continue. A provincial conference is being considered as a follow-up to the community consultations, to solve problems and share successes.

Implementation Planning

It is anticipated that the consultation process will result in the establishment of community planning committees to develop implementation plans. Communities may be at different stages of readiness for developing plans, and this will have an impact on the timetable of the reform. However, the following is an outline of the implementation activities that will occur over the next two to three years:

Consultation and Design:

- Organize community consultations.
- Develop community implementation plans.
- Continue program design and policy development.
- Plan provincial conference.

Management

- Establish Community Health and Support Services Division; set up local offices.
- Decentralize responsibility for planning, budgetary and system management.
- Introduce draft legislation.

Program

- Establish service access organizations, involving existing service providers.
- Establish an integrated in-home service program.
- Apply levels of care classification system to long-term care facilities.
- Complete chronic care role review.

Funding

- Continue to improve homemaker wages and related funding.
- Enhance funding to community support and in-home services.
- Convert to new funding approach for homes for the aged and nursing homes.

This implementation process includes a focused local process to encourage discussion and planning, and an integrated management structure to oversee the legislative, policy, and funding reforms.

Concluding Remarks

This paper provides a framework for considering the challenges of the present system and planning an integrated service system for the future. All interested parties are invited to review and comment on this document and to participate in the community planning that will occur during several years. Achieving the goals of the reform of long-term care will require the insights, experience, and expertise of all the partners in the system. By working together, we can shape a better future.

This implementation process includes a focused local process to encourage discussion and planning, and an integrated management structure to oversee the legislative, policy, and funding reforms.

Appendices

Appendix I
Current Long Term Care Programs in Ontario

1. Long Term Care Facilities

Program Name/Ministry/ Legislative Act	Program Purpose/Description of Services	88/89 Actual $ (Millions)	Municipal Contrib.	Financial Test	Availability
Municipal Homes for the Aged Ministry of Community and Social Services (MCSS) *Homes for Aged and Rest Homes Act*	▪ provide residential and extended care for frail elderly ▪ residential program nursing and personal care, usually less than 90 minutes per day, recreational programs, activation, pastoral care, etc. ▪ extended care program may offer continuous care with nursing supervision, reactivation, some rehabilitation, access to medical services and supplies and social and recreational activities ▪ requires medical examinations at least 6 months prior to admission	$256.8 (total residential and extended care) $20.7 (capital)	$86.4 (operating) $8.4 (capital)	▪ needs tested ▪ financial disclosure ▪ client, co-payment	88 homes province-wide
Charitable Homes for the Aged MCSS *Charitable Institutions Act*	Same as municipal homes for the aged	$75.6 (total residential and extended care) $4.6 (capital)		▪ needs tested, financial disclosure (for residential care) ▪ client co-payment (for extended care)	Total residential care and extended care 92 locations (22 charitable homes provide residential care, 70 provide both)

1. Long Term Care Facilities Continued

Program Name/Ministry/ Legislative Act	Program Purpose/Description of Services	88/89 Actual $ (Millions)	Municipal Contrib.	Financial Test	Availability
Nursing Homes Ministry of Health (MOH) *Nursing Homes Act* *Homes for Special Care Act* *Health Insurance Act* *Health Facilities Special Orders Act* *MOH Act*	▪ restore/maintain health status and functional capacity and meet psychosocial needs ▪ reactivation oriented maintenance care program on a 24 hour basis ▪ continuous care with medical and nursing supervision ▪ medical aids ▪ medical certificate for extended care ▪ direct application for admission	$395.1		client co-payment	333 homes
Chronic Care MOH *Public Hospital Act* *Private Hospitals Act* *Health Insurance Act* *MOH Act*	▪ assist chronically ill patients to attain and maintain their optimum levels of health ▪ provide diagnostic services, nursing care, medical management, physiotherapy, occupational therapy, speech pathology, social and recreational services, nutritional services, mechanical aids, drugs and medical supplies ▪ physician referral	$743.5		▪ client co-payment	176 locations

2. In-Home Services

Program Name/Ministry/ Legislative Act	Program Purpose/Description of Services	88/89 Actual $ (Millions)	Municipal Contrib.	Financial Test	Availability
Home Care Program MOH Acute and Chronic: *Health Insurance Act* School: *Education Amendment Act*	▪ provide visiting health and support services to eligible individuals in their own homes in order to avoid or delay the need for institutional admission or to promote earlier hospital discharge *Acute* ▪ requires minimum of 3 professional visits per month *Chronic* ▪ medical referral ▪ needs cannot be met on an outpatient basis ▪ nursing visits to maximum of 4 per day, enterostomal therapy, speech therapy, physiotherapy, occupational therapy, medical social work, nutritional counselling, respiratory technology, limited homemaking, diagnostic and lab services, medical supplies and dressing, hospital and sickroom equipment, transportation to medical appointments *School* ▪ students with special health needs in the publicly funded school system	$279.5 (total all programs)		▪ insured health service	38 local boards, province wide
Integrated Homemaker Program MCSS (administered by Home Care Program, MOH) *MCSS Act*	▪ provides services to elderly and to disabled adults in their homes ▪ supports the role of caregivers (families, friends) ▪ meal planning and marketing ▪ meal preparation and special diets	$34.8		None	18 of the 38 Home Care locations

2. In-Home Services Continued

Program Name/Ministry/ Legislative Act	Program Purpose/Description of Services	88/89 Actual $ (Millions)	Municipal Contrib.	Financial Test	Availability
	▪ cleaning ▪ laundry ▪ personal care				
Home Support Program (homemaking) MCSS *MCSS Act*	▪ to maintain elderly persons in the community by providing home help, homemaking services	($ in Community Support Services)			
Homemaking and nursing Services MCSS – homemaking MOH – nursing *Homemakers and Nurses Services Act*	▪ provide homemaking and nursing services to persons in their own homes ▪ provide meal planning, marketing, preparation of special diets, light, heavy and seasonal cleaning, laundry, dressing and bathing ▪ nursing provides health care upon request from physician ▪ no medical requirement for homemaking	$15.3	$3.5	▪ needs test for home-making	discretionary municipal program
Outreach Attendant Care MCSS *MCSS Act*	▪ provide attendant care services to individuals with physical disabilities in their own homes ▪ no medical requirement ▪ up to 90 hours (120 hours in special circumstances) of personal service per month	$6.1		none	43 outreach providers

3. Community Support Services

Program Name/Ministry/ Legislative Act	Program Purpose/Description of Services	88/89 Actual $ (Millions)	Municipal Contrib.	Financial Test	Availability
Volunteer Programs MCSS MCSS Act	▪ volunteer base ▪ provide resource information, referral and assistance to seniors ▪ Senior Volunteers in Service (SVIS)	$.4			
Home Support Program MCSS *MCSS Act*	▪ to maintain elderly persons in the community ▪ home maintenance, meals-on-wheels, escorted transportation, congregate dining, friendly visiting, security checks, day programs, and respite care ▪ information and referral ▪ no medical requirement or formal assessment required	$32.6	$4.7	none	▪ discretionary ▪ uneven ▪ 430 agencies
Day Programs MCSS *MCSS Act*	▪ social and recreational activities ▪ offered by religious, ethno-cultural and other organizations	not available			75 programs
Elderly Persons' Centres MCSS *Elderly Persons Centres Act* *MCSS Act*	▪ provide social, recreational, and cultural activities to seniors through daytime drop-in centres ▪ operated by municipalities or charitable non-profit organizations ▪ some centres provide home support services	$4.1 operating $1.1 capital	$5.1	None	182 EPCs

4. Specialized Programs

Program Name/Ministry/ Legislative Act	Program Purpose/Description of Services	88/89 Actual $ (Millions)	Municipal Contrib.	Financial Test	Availability
Day Hospital Programs MOH *Health Insurance Act* (Funding)	▪ provide an ambulatory setting for multi-disciplinary assessment and/ or short term rehabilitation, reactivation in order to enable the elderly to remain in the community ▪ full or half day programs ▪ nursing care and supervision; occupational therapy; physiotherapy ▪ recreational activities; meals ▪ speech pathology; social work; health education; nutritional care; personal care; chiropody; and referral services ▪ physician referral for those with stable medical condition requiring a few hours of therapy	$7.5 estimated operating, 89/90			35 locations province-wide equals 536 spaces
Regional Geriatric Program MOH *Health Insurance Act* *Public Hospitals Act*	▪ to assist elderly to live independently and prevent unnecessary/inappropriate institutionalization ▪ multi-level referral ▪ multi-disciplinary assessments ▪ regional assessment units provide: community health care; mental health care; long term care (chronic rehabilitation, extended care) emergency and acute care; out-patient beds; geriatric psychiatric beds; and long-term care beds	$8.1			3 RGPs: Ottawa, Hamilton, Toronto (2 locations, Kingston and London, are under review)
Alzheimer Community Support Services MCSS *MCSS Act*	▪ provide support to persons with dementia (e.g. Alzheimer's disease) and their family caregivers ▪ day program, respite care services, counselling and training for family caregivers	$5.5		none	60 programs

4. Specialized Programs Continued

Program Name/Ministry/ Legislative Act	Program Purpose/Description of Services	88/89 Actual $ (Millions)	Municipal Contrib.	Financial Test	Availability
Services for Persons with Senory Impairments MCSS *MCSS Act*	• to enable individuals with a primary impairment in hearing and sight impairments to function as independently as possibly • professional assessment • mobility training, training in alternative forms of communication, orientation to new environments, and use of assistive devices • on-going support through interpreters and interveners and other skilled workers	$12.0 (87/88 estimate)			

Appendix II
List of Strategies and Topics for Discussion

Strategy #1: Coordinate Access to Services

Recommendations for sponsorship of service access organizations based on provincial criteria.

Approaches to testing individualized funding approaches.

The adaption of service access organizations to geographically large, remote, and densely populated areas.

The relationship between service access organizations and service providers such as: long-term care facilities, the public health services, the acute care hospitals and hospital discharge planners, physicians and specialized services, especially Regional Geriatric Programs.

Strategy #2: Integrate and Consolidate In-Home Services

The roles of various types of in-home service providers in the integrated in-home service program.

New eligibility criteria for formal in-home services.

Human resources and training considerations for in-home services.

Self-management of personal support services.

Appoaches to ensuring in-home service flexibility and reponsiveness to individual needs.

Strategy #3: Enhance Community Support Services

The development of guidelines for the expansion of community support services, stressing the identification of gaps and under-served areas.

The encouragement of multi-service sponsors for community support services.

The encouragement and support of volunteerism in communities.

Strategy #4: Establish an Equitable and Flexible Funding Approach for Community Services

Reliable indicators for determination of need for community support and in-home services.

The advantages and disadvantages of various approaches to paying for community and in-home services in terms of their ability to ensure quality service, good administration, and cost control.

Strategy #5: Determine the Relationship Between Specialized Services and the Long-Term Care and Support Services System

The roles and responsibilities of specialized services in relation to the reformed service system.

Strategy #6: Enhance Support for Informal Caregivers

The role of community organizations and programs in providing support for informal caregivers.

The appropriate use of long-term care facilities for emergency respite and periodic care.

The development of alternative, innovative community support services for informal caregivers.

The early identification of caregiver needs and ways of informing caregivers about available supports.

Strategy #7: Reform Policies for Long-Term Care Facilities

Linkages between long-term care facilities and community-based services.

Linkages between long-term care facilities and service coordinators.

Linkages between long-term care facilities and acute care hospitals.

The level of care classification system and its implementation in Ontario's long-term care facilities.

Program models for respite care, convalescent and short-stay programming, and for community support services offered by facilities and planned in the community context.

Strategy #8: Introduce a Balanced Co-Payment Policy

The process of assessing consumers' ability to pay for support services.

Part III: Management of the System

Strategy #9: Establish an Integrated and Decentralized Management Structure

Strategy #10: Ensure Community Involvement in Planning Services

Appendix III
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